HOUSE BILL NO. 161

INTRODUCED BY MCNUTT

BY REQUEST OF THE DEPARTMENT OF LABOR AND INDUSTRY

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING CERTAIN WORKERS' COMPENSATION LAWS; REQUIRING INSOLVENT INSURERS TO PROVIDE CLAIM SUMMARY INFORMATION; CLARIFYING THE PENALTY PROVISIONS FOR LATE REPORT FILING BY INSURERS; REMOVING THE MEDICAL PROVIDER OATH REQUIREMENT FOR DOCUMENTING THE PROVISION OF SERVICES; ~~PROVIDING A PENALTY FOR DIRECT PAYMENT OF BENEFITS BY AN EMPLOYER;~~ CLARIFYING THE UNINSURED EMPLOYERS' FUND CLAIM REIMBURSEMENT AUTHORITY; UPDATING TERMINOLOGY RELATING TO HOSPITALS; REVISING SUBSEQUENT INJURY FUND ASSESSMENT PROVISIONS; REVISING PLAN NO. 1 APPROVAL CRITERIA; SPECIFYING THAT INTEREST ON PLAN NO. 1 LIQUIDATED SECURITY DEPOSITS IS TO BE USED TO PAY CLAIMS; REQUIRING AN INSURER TO SUBMIT NOTICE OF COVERAGE AND CANCELLATIONS ELECTRONICALLY TO THE DEPARTMENT OF LABOR AND INDUSTRY; PROHIBITING THE SPLITTING OF WORKERS' COMPENSATION RISKS AMONG VARIOUS INSURANCE PLANS; ELIMINATING THE WORKERS' COMPENSATION REGULATION ADVISORY COUNCIL; AMENDING SECTIONS 39-71-306, 39-71-315, ~~39-71-435,~~ 39-71-504, 39-71-704, 39-71-915, 39-71-2105, 39-71-2108, 39-71-2203, 39-71-2204, 39-71-2205, 39-71-2336, 39-71-2337, AND 39-71-2339, MCA; REPEALING SECTION 2-15-1709, MCA; AND PROVIDING EFFECTIVE DATES AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Claim summary and actuarial documentation.** If a plan No. 2 insurer becomes insolvent and is placed into receivership, declares bankruptcy, or seeks protection from its creditors, the insurer, upon request of the department, shall submit to the department claim summary and actuary information for the insurer's Montana workers' compensation and occupational disease claims.

Section 2. Section 39-71-306, MCA, is amended to read:

"39-71-306. Insurers to file summary reports of benefits paid for injuries and miscellaneous expenses and statements of medical expenditures. (1) Each insurer shall, on or before the 15th day after

each state government fiscal quarter ends, file with the department:

(a) summary reports of benefits for all compensation payments made during the previous state fiscal quarter to injured workers or their beneficiaries or dependents;

(b) statements showing the amounts expended during the previous state fiscal quarter for all medical services for injured workers; and

(c) statements showing all miscellaneous amounts, other than compensation and medical expenditures, paid during the previous state fiscal quarter to or on behalf of injured workers or their beneficiaries or dependents and not otherwise reported as an expenditure for the workers' compensation administration assessment provided for in 39-71-201.

(2) An insurer that fails to file the summary report required by this section or the annual paid losses report required in 39-71-201 ~~after a 5-day grace period~~ within 5 days after the date on which ~~the~~ either report is due may be assessed a penalty in an amount of not less than $250 or more than $1,000 to be deposited in the workers' compensation administration fund."

Section 3. Section 39-71-315, MCA, is amended to read:

"39-71-315. Prohibited actions -- penalty. (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (2):

(a) failing to ~~document, under oath,~~ certify the provision of the services or treatment for which compensation is claimed under chapter 72 or this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under chapter 72 or this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person who violates this section may be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty. Penalties collected pursuant to this section must be paid into the state general fund. The workers' compensation court has jurisdiction over actions brought to collect the penalty and over disputes concerning the penalty assessment. Disputes brought pursuant to this section are not subject to mediation.

(3) Subsection (1)(b) does not apply to medical services provided to an injured worker by a treating physician with an ownership interest in a managed care organization that has been certified by the department."

~~**Section 4.** Section 39-71-435, MCA, is amended to read:~~

~~**"39-71-435. Workers' compensation and employers' liability insurance -- optional deductibles.** (1) An insurer issuing a workers' compensation or an employer's liability insurance policy may offer to the policyholder, as part of the policy or by endorsement, optional deductibles for benefits payable under the policy consistent with the standards contained in subsection (3).~~

~~(2) The advisory organization designated under 33-16-1023 may develop and file a deductible plan or plans on behalf of its members consistent with the standards contained in subsection (3).~~

~~(3) The commissioner of insurance shall approve a deductible plan that is in accordance with the following standards:~~

~~(a) Claimants' rights are properly protected and claimants' benefits are paid without regard to the deductible.~~

~~(b) Premium reductions reflect the type and level of the deductible, consistent with accepted actuarial standards.~~

~~(c) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount.~~

~~(d) Recognition is given to policyholder characteristics, including but not limited to size, financial capabilities, nature of activities, and number of employees.~~

~~(e) The policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.~~

~~(f) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.~~

~~(g) Failure by the policyholder to reimburse deductible amounts to the insurer is treated under the policy as nonpayment of premium.~~

~~(h) Losses subject to the deductible must be reported and recorded as losses for purposes of calculating rates for a policyholder on the same basis as losses under policies providing first dollar coverage.~~

~~(4) The state compensation insurance fund, plan No. 3, may adopt the plan filed by the designated advisory organization or adopt an optional deductible plan that meets the requirements of this section.~~

~~(5) For purposes of 39-71-201 and 39-71-915, liability for assessments must be ascertained without regard to application of any deductible, whether the employer or the insurer pays the losses. For all other taxes~~

~~and assessments based on premium, the amount of premium or assessment must be determined after application of the deductible.~~

~~(6) A plan No. 2 or plan No. 3 policyholder who pays medical, wage loss, or any other benefits that are payable pursuant to chapter 72 or this chapter directly to the claimant or service provider is subject to a penalty of $500 for each payment made. Penalties collected under this subsection must be deposited in the uninsured employers' fund established in 39-71-503."~~

Section 4. Section 39-71-504, MCA, is amended to read:

"39-71-504. Funding of fund -- option for agreement between department and injured employee. The fund is funded in the following manner:

(1) (a) The department may require that the uninsured employer pay to the fund a penalty of either up to double the premium amount the employer would have paid on the payroll of the employer's workers in this state if the employer had been enrolled with compensation plan No. 3 or $200, whichever is greater. In determining the premium amount for the calculation of the penalty under this subsection, the department shall make an assessment based on how much premium would have been paid on the employer's past 3-year payroll for periods within the 3 years when the employer was uninsured.

(b) The fund shall collect from an uninsured employer an amount equal to all benefits paid or to be paid from the fund to or on behalf of an injured employee of the uninsured employer.

(c) In addition to any amounts recovered under subsections (1)(a) and (1)(b), the fund shall collect a penalty of $200 from an employer that fails to obtain Montana workers' compensation insurance within 30 days of notice of the requirement.

(2) (a) An uninsured employer that fails to make timely penalty or claim reimbursement payments required under this part must be assessed a late fee of $50 for each late payment.

(b) Any unpaid balance owed to the fund under this part ~~for penalties or claim reimbursement~~ must accrue interest at 12% a year or 1% a month or fraction of a month. Interest on unpaid balances accrues from the date of the original billing.

(c) Late fees and interest assessed pursuant to this subsection (2) must be deposited into the fund for payment of administrative expenses and benefits.

(3) The department may enter into an agreement with the injured employee or the employee's beneficiaries to assign to the employee or the beneficiaries all or part of the funds collected by the department

from the uninsured employer pursuant to subsection (1)(b)."

Section 5. Section 39-71-704, MCA, is amended to read:

"39-71-704. Payment of medical, hospital, and related services -- fee schedules and hospital rates -- fee limitation. (1) In addition to the compensation provided under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

(a) After the happening of a compensable injury and subject to other provisions of this chapter, the insurer shall furnish reasonable primary medical services for conditions resulting from the injury for those periods as the nature of the injury or the process of recovery requires.

(b) The insurer shall furnish secondary medical services only upon a clear demonstration of cost-effectiveness of the services in returning the injured worker to actual employment.

(c) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

(d) (i) The insurer shall reimburse a worker for reasonable travel, lodging, meals, and miscellaneous expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the department. Reimbursement must be at the rates allowed for reimbursement for state employees.

(ii) Rules adopted under subsection (1)(d)(i) must provide for submission of claims, within 90 days from the date of travel, following notification to the claimant of reimbursement rules, must provide procedures for reimbursement receipts, and must require the use of the least costly form of travel unless the travel is not suitable for the worker's medical condition. The rules must exclude from reimbursement:

(A) 100 miles of automobile travel for each calendar month unless the travel is requested or required by the insurer pursuant to 39-71-605;

(B) travel to a medical provider within the community in which the worker resides;

(C) travel outside the community in which the worker resides if comparable medical treatment is available within the community in which the worker resides, unless the travel is requested by the insurer; and

(D) travel for unauthorized treatment or disallowed procedures.

(iii) An insurer is not liable for injuries or conditions that result from an accident that occurs during travel or treatment, except that the insurer retains liability for the compensable injuries and conditions for which the travel and treatment was required.

(e) Except for the repair or replacement of a prosthesis furnished as a result of an industrial injury, the benefits provided for in this section terminate when they are not used for a period of 60 consecutive months.

(f) Notwithstanding subsection (1)(a), the insurer may not be required to furnish, after the worker has achieved medical stability, palliative or maintenance care except:

(i) when provided to a worker who has been determined to be permanently totally disabled and for whom it is medically necessary to monitor administration of prescription medication to maintain the worker in a medically stationary condition;

(ii) when necessary to monitor the status of a prosthetic device; or

(iii) when the worker's treating physician believes that the care that would otherwise not be compensable under subsection (1)(f) is appropriate to enable the worker to continue current employment or that there is a clear probability of returning the worker to employment. A dispute regarding the compensability of palliative or maintenance care is considered a dispute over which, after mediation pursuant to department rule, the workers' compensation court has jurisdiction.

(g) Notwithstanding any other provisions of this chapter, the department, by rule and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment that the department finds to be unscientific, unproved, outmoded, or experimental.

(2) The department shall annually establish a schedule of fees for medical services not provided at a hospital that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The department may require insurers to submit information to be used in establishing the schedule.

(3) (a) The department shall establish rates for hospital services necessary for the treatment of injured workers.

(b) Except as provided in subsection (3)(g), rates for services provided at a hospital must be the greater of:

(i) 69% of the hospital's January 1, 1997, usual and customary charges; or

(ii) the discount factor established by the department that was in effect on June 30, 1997, for the hospital. The discount factor for a hospital formed by the merger of two or more existing hospitals is computed by using the weighted average of the discount factors in effect at the time of the merger.

(c) Except as provided in subsection (3)(g), the department shall adjust hospital discount factors so that the rate of payment does not exceed the annual percentage increase in the state's average weekly wage, as

defined in 39-71-116.

(d) The department may establish a fee schedule for hospital outpatient services rendered. The fee schedule must, in the aggregate, provide for fees that are equal to the statewide average discount factors paid to hospitals to provide the same or equivalent procedure to workers' compensation hospital outpatients.

(e) The discount factors established by the department pursuant to this subsection (3) may not be less than medicaid reimbursement rates.

(f) For services available in Montana, insurers are not required to pay facilities located outside Montana rates that are greater than those allowed for services delivered in Montana.

(g) For a ~~hospital licensed as a~~ medical assistance facility or a critical access hospital licensed pursuant to Title 50, chapter 5, the rate for services is the ~~hospital's~~ usual and customary charge. Fees paid to a ~~hospital licensed as a~~ licensed medical assistance facility or critical access hospital are not subject to the limitation provided in subsection (4).

(4) The percentage increase in medical costs payable under this chapter may not exceed the annual percentage increase in the state's average weekly wage, as defined in 39-71-116.

(5) Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section.

(6) Disputes between an insurer and a medical service provider regarding the amount of a fee for medical services must be resolved by a hearing before the department upon written application of a party to the dispute.

(7) (a) After the initial visit, the worker is responsible for $25 of the cost of each subsequent visit to a hospital emergency department for treatment relating to a compensable injury or occupational disease.

(b) "Visit", as used in this subsection (7), means each time that the worker obtains services relating to a compensable injury or occupational disease from:

(i) a treating physician;

(ii) a physical therapist;

(iii) a psychologist; or

(iv) hospital outpatient services available in a nonhospital setting.

(c) A worker is not responsible for the cost of a subsequent visit pursuant to subsection (7)(a) if the visit is for treatment requested by an insurer."

Section 6. Section 39-71-915, MCA, is amended to read:

"39-71-915. Assessment of insurer -- employers -- definition -- collection. (1) As used in this section, "paid losses" means the following benefits paid during the preceding calendar year for injuries covered by the Montana Workers' Compensation Act and the Occupational Disease Act of Montana without regard to the application of any deductible, regardless of whether the employer or the insurer pays the losses:

(a) total compensation benefits paid; and

(b) except for medical benefits in excess of $200,000 for each occurrence that are exempt from assessment, total medical benefits paid for medical treatment rendered to an injured worker, including hospital treatment and prescription drugs.

(2) The fund must be maintained by assessing each plan No. 1 employer, each employer insured by a plan No. 2 insurer, plan No. 3, the state fund, with respect to claims arising before July 1, 1990, and each employer insured by plan No. 3, the state fund. The assessment amount is the total amount ~~of paid losses reimbursed from~~ paid by the fund in the preceding ~~calendar~~ fiscal year and the expenses of administration less other realized income that is deposited in the fund. The total assessment amount to be collected must be allocated among plan No. 1 employers, plan No. 2 employers, plan No. 3, the state fund, and plan No. 3 employers, based on a proportionate share of paid losses for the calendar year preceding the year in which the assessment is collected. The board of investments shall invest the money of the fund, and the investment income must be deposited in the fund.

(3) On or before May 31 each year, the department shall notify each plan No. 1 employer, plan No. 2 insurer, and plan No. 3, the state fund, of the amount to be assessed for the ensuing fiscal year. The amount to be assessed against the state fund must separately identify the amount attributed to claims arising before July 1, 1990, and the amount attributable to state fund claims arising on or after July 1, 1990. On or before April 30 each year, the department, in consultation with the advisory organization designated under 33-16-1023, shall notify plan No. 2 insurers and plan No. 3 of the premium surcharge rate to be effective for policies written or renewed on and after July 1 in that year.

(4) The portion of the plan No. 1 assessment assessed against an individual plan No. 1 employer is a proportionate amount of total plan No. 1 paid losses during the preceding calendar year that is equal to the percentage that the total paid losses of the individual plan No. 1 employer bore to the total paid losses of all plan No. 1 employers during the preceding calendar year.

(5) The portion of the assessment attributable to state fund claims arising before July 1, 1990, is the

proportionate amount that is equal to the percentage that total paid losses for those claims during the preceding calendar year bore to the total paid losses for all plans in the preceding calendar year. As required by 39-71-2352, the state fund may not pass along to insured employers the cost of the subsequent injury fund assessment that is attributable to claims arising before July 1, 1990.

(6) The remaining portion of the assessment must be paid by way of a surcharge on premiums paid by employers being insured by a plan No. 2 insurer or plan No. 3, the state fund, for policies written or renewed annually on or after July 1. The surcharge rate must be computed by dividing the remaining portion of the assessment by the total amount of premiums paid by employers insured under plan No. 2 or plan No. 3 in the previous calendar year. The numerator for the calculation must be adjusted as provided by subsection (9).

(7) Each plan No. 2 insurer providing workers' compensation insurance and plan No. 3, the state fund, shall collect from its policyholders the assessment premium surcharge provided for in subsection (6). When collected, the assessment premium surcharge may not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but, for the purpose of collection, must be treated as separate costs imposed upon insured employers. The total of this assessment premium surcharge must be stated as a separate cost on an insured employer's policy or on a separate document submitted by the insured employer and must be identified as "workers' compensation subsequent injury fund surcharge". Each assessment premium surcharge must be shown as a percentage of the total workers' compensation policyholder premium. This assessment premium surcharge must be collected at the same time and in the same manner that the premium for the coverage is collected. The assessment premium surcharge must be excluded from the definition of premiums for all purposes, including computation of insurance producers' commissions or premium taxes, except that an insurer may cancel a workers' compensation policy for nonpayment of the assessment premium surcharge. Cancellation must be in accordance with the procedures applicable to the nonpayment of premium. If an employer fails to remit to an insurer the total amount due for the premium and assessment premium surcharge, the amount received by the insurer must be applied to the assessment premium surcharge first and the remaining amount applied to the premium due.

(8) (a) All assessments paid to the department must be deposited in the fund.

(b) Each plan No. 1 employer shall pay its assessment by July 1.

(c) Each plan No. 2 insurer and plan No. 3, the state fund, shall remit to the department all assessment premium surcharges collected during a calendar quarter by not later than 20 days following the end of the quarter.

(d) The state fund shall pay the portion of the assessment attributable to claims arising before July 1, 1990, by July 1.

(e) If a plan No. 1 employer, a plan No. 2 insurer, or plan No. 3, the state fund, fails to timely pay to the department the assessment or assessment premium surcharge under this section, the department may impose on the plan No. 1 employer, the plan No. 2 insurer, or plan No. 3, the state fund, an administrative fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%. Administrative fines and interest must be deposited in the fund.

(9) The amount of the assessment premium surcharge actually collected pursuant to subsection (7) must be compared each year to the amount assessed and upon which the premium surcharge was calculated. The amount undercollected or overcollected in any given year must be used as an adjustment to the numerator provided for by subsection (6) for the following year's assessment premium surcharge.

(10) If the total assessment is less than $200,000 for any year, the department may defer the assessment amount for that year and add that amount to the assessment amount for the subsequent year."

Section 7. Section 39-71-2105, MCA, is amended to read:

"39-71-2105. Additional proof of solvency -- revocation of order. (1) The department, with the concurrence of the Montana self-insurers guaranty fund, may at any time require from any employer acting under compensation plan No. 1 additional proof of solvency and financial ability to pay the ~~compensation~~ benefits provided by this chapter ~~and may at any time, upon notice to the employer of not less than 10 or more than 20 days, after and upon a full hearing, revoke any order or approval~~.

(2) The department may, after providing an opportunity for an administrative review conference to consider information submitted by a plan No. 1 employer, revoke any order of approval upon 20 days' notice to the employer. A decision to revoke approval involving a plan No. 1 employer who is a member of the Montana self-insurers guaranty fund requires the concurrence of the guaranty fund. A plan No. 1 employer that is dissatisfied with the decision following the administrative review conference may appeal the decision and request a contested case hearing pursuant to 39-71-2401(2).

(3) A decision revoking an order of approval is final unless the employer files an appeal with the department within 20 days of the issuance of the notice. An employer may not continue to self insure after the 20-day period provided for in subsection (2) has expired unless the department is satisfied that the employer has provided sufficient security and financial ability to pay the ~~compensation~~ BENEFITS provided by this chapter.

A decision issued pursuant to this subsection involving a plan No. 1 employer who is a member of the Montana self-insurers guaranty fund requires the concurrence of the guaranty fund."

Section 8. Section 39-71-2108, MCA, is amended to read:

"39-71-2108. Failure of employer to pay ~~compensation~~ benefits -- duty of department. Upon the failure of the employer to pay any ~~compensation~~ benefits provided for in this chapter upon the terms~~, and~~ in the amounts, and at the times when the ~~same becomes~~ benefits become due and payable, the department shall, upon demand of the person to whom ~~compensation is~~ benefits are due, apply any deposits made with the department to the payment of the ~~same~~ benefits, and the department shall take the proper steps to convert any securities on deposit with the department or sufficient ~~thereof~~ deposits ~~into cash and~~ to pay ~~the same cash upon~~ the liabilities of the employer accruing under the terms of this chapter~~, and the~~. The department shall, when necessary, collect and enforce the collection of the liability of all sureties upon any bonds ~~which~~ that may be given by the employer to ~~insure~~ ensure the payment of ~~his~~ the employer's liability. ~~To these ends and for these purposes, the~~ The department ~~shall be deemed to be~~ is considered the owner of the deposit and security and the obligee in the bond in trust for the purposes and may proceed in its own name to recover upon the bonds or foreclose and liquidate the securities. All interest earnings on liquidated security deposits must be retained by the department for payment of benefits pursuant to this section."

Section 9. Section 39-71-2203, MCA, is amended to read:

"39-71-2203. Content of policies -- policies subject to approval, change, or revision by department. (1) All policies insuring the payment of compensation under this chapter must contain a clause to the effect that, as between the employee and the insurer~~,~~:

(a) the notice to or knowledge of the occurrence of the injury on the part of the insured ~~shall be deemed~~ constitutes notice or knowledge, as the case may be, on the part of the insurer;

(b) ~~that~~ jurisdiction of the insured for the purpose of this chapter ~~shall be~~ is the jurisdiction of the insurer; and

(c) ~~that~~ the insurer ~~shall~~ is in all things ~~be~~ bound by and subject to the awards, orders, judgments, or decrees rendered against ~~such~~ the insured.

(2) ~~No such~~ A policy ~~shall~~ may not be issued unless it contains the agreement of the insurer that it will promptly pay to the person entitled to compensation all the installments of compensation or other payments

provided for in this chapter ~~provided for~~ and that the obligation ~~shall~~ is not ~~be~~ affected by any default of the insured after the injury or by any default in the giving of any notice required by ~~such~~ the policy or by this chapter or otherwise. ~~Such~~ The agreement ~~shall~~ must be construed to be a direct promise by the insured to the person entitled to compensation.

(3) Every policy or contract insuring against liability for compensation under compensation plan No. 2 must contain a clause to the effect that the insurer ~~shall be~~ is directly and primarily liable to and will pay directly to the employee or in case of death to ~~his~~ the employee's beneficiaries or major or minor dependents~~,~~ the compensation, if any, for which the employer is liable.

(4) Every ~~such~~ policy ~~shall~~ must at all times be subject to approval, change, or revision by the department and ~~shall~~ must contain the clauses, agreements, and promises required by this chapter.

(5) All Montana operations of an employer, as defined in 39-71-117, covered under plan No. 2 must be insured by the same insurer."

Section 10. Section 39-71-2204, MCA, is amended to read:

"39-71-2204. Insurer to submit notice of coverage within thirty days -- penalty for failure. (1) The insurer shall, within 30 days after the issuance of the policy of workers' compensation insurance, submit to the department the notice of coverage stating the effective date of the policy insuring the employer and other information that may be required by the department. Beginning January 1, 2006, notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for authorized workers' compensation insurers in Montana; and

(b) shall, under terms and conditions acceptable to the department, accept notice of coverage received from the agents recognized under subsection (2)(a) as the insurer's notice of coverage.

(3) The department may, in its discretion, assess a penalty of no more than $200 against an insurer that as a general business practice does not comply with the 30-day notice requirement set forth in subsection (1)."

Section 11. Section 39-71-2205, MCA, is amended to read:

"39-71-2205. Policy in effect until canceled or replaced -- twenty-day notification of cancellation required -- penalty. (1) The policy remains in effect until canceled, and cancellation may take effect only by

written notice to the named insured and to the department at least 20 days prior to the date of cancellation. However, the policy terminates on the effective date of a replacement or succeeding workers' compensation insurance policy issued to the insured. Nothing in this section prevents an insurer from canceling a policy of workers' compensation insurance before a replacement policy is issued to the insured. Beginning January 1, 2006, notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for authorized workers' compensation insurers in Montana; and

(b) shall, under terms and conditions acceptable to the department, accept notice of cancellation received from the agents recognized under subsection (2)(a) as the insurer's notice of cancellation.

(3) (a) The department may assess a penalty of up to $200 against an insurer that does not comply with the notice requirement in subsection (1).

(b) An insurer may contest the penalty assessment in a hearing conducted according to department rules."

Section 12. Section 39-71-2336, MCA, is amended to read:

"39-71-2336. Manner of electing -- contract or policy of insurance -- payment of premium. The state fund shall prescribe the procedure by which an employer may elect to be bound by compensation plan No. 3, the effective time of the election, and the manner in which the election is terminated for reasons other than default in payment of premiums. Every employer electing to be bound by compensation plan No. 3 must receive from the state fund a contract or policy of insurance in a form approved by the department. All Montana operations of an employer, as defined in 39-71-117, covered by compensation plan No. 3 must be insured by the state compensation insurance fund. The premium must be paid by the employer to the state fund at ~~such~~ times ~~as~~ that the state fund prescribes and must be paid over by the state fund to the state treasurer to the credit of the state fund."

Section 13. Section 39-71-2337, MCA, is amended to read:

"39-71-2337. State fund to submit notice of coverage within thirty days -- penalty for failure. (1) The state fund shall, within 30 days after the issuance of an insurance policy, submit to the department the notice of coverage stating the effective date of the policy insuring the employer and other information the department

requires. Beginning January 1, 2006, notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for the state fund; and

(b) shall, under terms and conditions acceptable to the department, accept notice of coverage received from the agents recognized under subsection (2)(a) as the state fund's notice of coverage.

(3) The department may assess a penalty of no more than $200 against the state fund if, as a general business practice, the state fund does not comply with the 30-day notice requirement."

Section 14. Section 39-71-2339, MCA, is amended to read:

"39-71-2339. Cancellation of coverage -- twenty days' notice required. (1) The state fund may cancel an employer's coverage under this part for failure to report payroll or pay the premiums due or for another cause provided in the insurance policy. Cancellation may take effect only by written notice to the named insured and the department at least 20 days prior to the date of cancellation or, in cases of nonreporting of payroll or nonpayment of a premium, by failure of the employer to submit payroll reports or pay a premium within 20 days after the due date. The state fund shall notify the department of the names and effective dates of all policies canceled. However, the policy terminates on the effective date of a replacement or succeeding insurance policy issued to the insured. This section does not prevent the state fund from canceling an insurance policy before a replacement policy is issued to the insured. After the cancellation date, the employer has the same status as an employer who is not enrolled under the Workers' Compensation Act unless a replacement or succeeding insurance policy has been issued. Beginning January 1, 2006, notice to the department under this section must be provided electronically.

(2) The department:

(a) may recognize the advisory organization designated under 33-16-1023 or recognize other organizations as agents for the state fund; and

(b) shall, under terms and conditions acceptable to the department, accept notice of cancellation received from the agents recognized under subsection (2)(a) as the state fund's notice of cancellation.

(3) (a) The department may assess a penalty of up to $200 against the state fund if it does not comply with the notice requirement in subsection (1).

(b) The state fund may contest the penalty assessment in a hearing conducted according to department rules."

NEW SECTION. **Section 15. Repealer.** Section 2-15-1709, MCA, is repealed.

NEW SECTION. **Section 16. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 39, chapter 71, part 22, and the provisions of Title 39, chapter 71, part 22, apply to [section 1].

NEW SECTION. **Section 17. Effective dates -- applicability.** (1) Except as provided in subsection (2), [this act] is effective July 1, 2005.

(2) [Sections ~~5 and 7~~ 4 AND 6 and this section] are effective on passage and approval.

(3) [Sections ~~10 and 13~~ 9 AND 12] apply to policies written or renewed on or after July 1, 2005.

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